No. 2. January, 1912. Vol. V.

Bulletin

OF THE

Ontario Hospitals for the Insane

A Journal Devoted to the interests of Psychiatry in Ontario

Printed by Order of the Legislative Assembly

For the Department of the Provincial Secretary.

Printed by L. K. Cameron, Printer to the King's Most Excellent Majesty.

PROCEDURE TO SECURE ADMISSION OF PATIENTS TO ONTARIO HOSPITALS FOR THE INSANE.

---

(1) Where the property of a patient is sufficient, or his friends are willing to pay the cost of the Medical Examination, the family Physician should apply directly to the Medical Superintendent of the Hospital for the Insane, in whose district the patient resides, for the necessary blank forms. These being secured, they should be properly and fully filled in, dated, signed in presence of two witnesses by the medical men in attendance. They are then returned to the Hospital, and if satisfactory, and there is accommodation, advice will be sent at once to have the patient transferred. See R.S.O., Cap. 317, sections 7, 8, 9.

(2) Where the patient has no property, and no friends willing to pay the cost, application should be made to the head of the Municipality where he lives, who, after satisfying himself that the patient is destitute, may order the examination to be made by two physicians, and a similar course to the above is then followed. The Council of the Municipality is liable for all costs incurred, including expenses of travel. See R.S.O., Cap. 317, section 11, subsections 1 and 2.

(3) Where the patient is suspected to be dangerously insane, information should be laid before a magistrate, who may issue a Warrant for the apprehension of the patient, and if satisfied that he is dangerously insane may commit the patient to the gaol, or some safe place of confinement, and notify the Medical Examiners. The Magistrate should then send to the Inspector of Prisons and Public Charities, Parliament Buildings, Toronto, all the information, evidence and certificates of insanity. The costs incurred by this method form a charge against the County, City or Town in which such patient resided. See R.S.O., Cap. 317, sections 12 to 20.

No. 2. January, 1912. Vol. V.

Bulletin

OF THE

Ontario Hospitals for the Insane

A Journal Devoted to the interests of Psychiatry in Ontario

Printed by Order of the Legislative Assembly.

FOR THE DEPARTMENT OF THE PROVINCIAL SECRETARY.

Printed by L. K. CAMERON, Printer to the King's Most Excellent Majesty.

TABLE OF CONTENTS.

PAGE

Insanity in Its Legal Aspects. By the Honourable William Renwick Riddell, L.H.D., etc. Justice King's Bench Division, H. C. of J., Ontario..... 3

The Insane in Japan. By Frederick Peterson, M.D., Professor of Psychiatry, Columbia University, New York 10

Voluntary Admissions to the Hospital for Insane, Toronto. By J. M. Forster, Medical Superintendent 18

Five Hundred Consecutive Admissions to the Hospital for Insane, London. By W. J. Robinson, M.D., Medical Superintendent 25

A Case of Dementia Præcox Paranoia of Long Standing, with Delusions, but no Perceptible Deterioration of Senses. By J. F. Cattermole, M.D., Assistant Superintendent, Hospital for Insane, Penetanguishene, Ont. 31

Case of Paranoidal Dementia Præcox with Early Symptoms Resembling Those of Paresis. By W. A. Marshall, Assistant Physician, Hospital for Insane, Hamilton 35

A Common Skin Disease Seen in the Hospitals for the Insane—Psoriasis. By C. M. Crawford, M.D., Assistant Physician, Hospital for the Insane, Brockville 46

A Case of Aneurysm, Associated with General Paresis. By C. S. McVicar, M.B., Pathologist to Toronto Hospital for Insane. Assistant in Clinical Medicine, University of Toronto..... 55

Book Reviews 62

The Bulletin

OF THE

Ontario Hospitals for the Insane

A Journal Devoted to the Interests of Psychiatry in Ontario.

INSANITY IN ITS LEGAL ASPECTS.

By the Honourable William Renwick Riddell, L. H. D., etc.

Justice King's Bench Division, H. C. of J., Ontario.

A Word with Alienists.

Early one morning a doctor and a policeman going along the street found a man lying opposite a store. Enquiry soon disclosed that he had a broken leg. To the medical man the sufferer at once became the patient, but to the policeman he remained but a possible burglar. To the doctor it made no difference whether the man was the most hardened criminal in the world; his art and science are wholly at the disposal of a Bill Sykes as of a Seth Pecksniff or a Ned Cheeryble. To the policeman it made no difference whether the stranger had one broken bone or fifty, whether there could be a cure without shortening or whether he could ever expect to walk with ease again. What the policeman was concerned with was, "had the man been breaking the law? and, if so, what was the available evidence?"

They both took part in conveying him to the hospital, the doctor that there might be a better chance of perfect recovery, the policeman that he might the better know where to put his hand upon the suspected. Had a clergy-

man happened along, he would probably have been anxious about the poor man's spiritual condition and the salvation of his soul; these to the physician were only of importance as they bore upon the treatment and prognosis (and that would be almost if not quite infinitesimal), while the policeman, as policeman, would care nothing about it at all, and not be inquisitive even as to whether the man had a soul at all, and, if so, whether it was worth saving or trying to save. Now, none of these viewpoints is higher than either of the others, but all are radically different.

It is from not bearing in mind the different aspects from which the same facts are to be and are considered, that there is so much disputing about the insane; so much time wasted in the courts over expert testimony, and so much contempt expressed by the lawyer for the medical expert on insanity which is only equalled by the contempt of many a medical expert for the rules of law in that respect.

If it should happen that a judge were to be called in by a medical man to assist in the treatment of an insane man, he would necessarily follow out the methods of medical treatment. And so where a medical man is called upon to assist in the administration of the law, he must adapt himself for that occasion to the principles of the law. Neither judge nor lawyer need, while assisting in the province of the other, abandon the views he holds in his own province, nor does he. To the medical man the insane person is a sick man to be treated for his disease, and it is a matter of indifference whether he is a criminal or not; to the judge it is a matter of indifference whether a prisoner or a litigant be insane or not, the question is, is he capable of making a contract, is he responsible for his acts? One more thing before attacking our main theme—the judge does not make the law; that is either a matter of tradition or of legislation, in either case of binding authority. He cannot change or avoid the law—for which he is no more responsible than the doctor is for

the insanity of a patient or for the laws of nature governing insanity. And this law is binding upon all citizens, and all good citizens should obey the law in this as in all else. If the law does not suit the doctor or any one else, he may do his best to have it changed by Parliament; but it is the bounden duty of every one to obey the law so long as it is law.

As most of the instances in which medical men come in contact with the law are cases of insanity, real or alleged, I have thought it not without advantage to deal with the law in respect of insanity so far as medical men are likely to be affected.

Sometimes a doctor is called upon to examine one alleged to be insane, in order that he may be committed or declared by the courts to be insane. The opinion of a medical man is practically worthless if given simply as an opinion. The Court determines the question of insanity, and requires the medical witness to set out in his affidavit in full his reasons for his conclusions. Care should be taken to preserve and transmit all the conversation (if any) and all other indicia from which the practitioner has formed his judgment.

Again, and this is the most frequent case, a medical man is called as a witness in court upon the question of insanity. He may be an ordinary, though skilled, witness to set out the facts of the condition of the person whose mental state is under investigation, or he may be an expert witness called simply to give an opinion, or he may act in each capacity.

A witness should always bear in mind that he is not the person who is to decide any question of fact; that is for the Court or the jury, as the case may be; nor is he to decide any question of law, that is for the judge alone.

The most commonly occurring occasions for such evidence are (1) when the capacity of a testator to make a will is under investigation, and (2) when the question is whether one who has committed a violent act is responsible to the criminal law.

In neither of these inquiries is the insanity of the party *in itself* of the slightest moment—hundreds of insane persons have made valid wills, and hundreds of insane persons have been executed. If people do not like that law, let them get it changed; but for the present that is the law.

That medical men may know how to conduct their examinations, and in what direction to make and to press their enquiries (for a superficial enquiry is often worse than none at all), I set out the rules of law in each case.

In the case of wills it was for a long time thought to be the law that if the mind of the testator were affected by insanity at all, since the mind was supposed to be one single and indivisible entity, then, being affected, it must be unsound, and, as a consequence, testamentary capacity was wanting. As it was put, "Any degree of mental unsoundness, however slight, and however unconnected with the testamentary disposition in question, must be held fatal to the capacity of a testator." But that is not the law.

If one making a will understands what a will is, what its effects are and that he is making a will—if he understands the extent of the property he is disposing of—if he is able to comprehend, remember and appreciate the claims to which he should give effect, for example, claims of relatives, then he is far on the way to be considered competent to make a will, although he may be and may for years have been insane. Then, in the consideration of the claims to which he should give effect, there must be no disorder of the mind which poisons his affections, or which perverts his sense of right, or prevents the exercise of his natural faculties. Such would destroy or, at least, imperil his testamentary capacity.

The mere fact of the existence of delusions may not be of importance—it is not of importance if the delusion neither exercises nor is calculated to exercise any influence on the particular disposition of property, and a rational and proper will is the result. But if the insane

delusion influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have made, that disposition is bad.

A medical man called upon to examine a person as to his testamentary capacity should, therefore, carefully inquire into

(1) His appreciation of the nature of a will and its effects.

(2) His appreciation of the property he has to dispose of.

(3) His appreciation of the property he was disposing of by will.

(4) His recollection of persons having claims by kin or otherwise upon his bounty, and his comprehension and appreciation of such claims.

(5) His mental condition, whether so disordered by insanity of any form as to affect his disposition toward such persons, or to change his normal view of right, or to prevent the exercise of his faculties.

(6) Are there any delusions?

(7) If so, are they of such a nature as to influence him in disposing of his property otherwise than he would were the delusions absent?

In criminal cases, the question of the existence of insanity is also wholly unimportant. It is not the law that an insane man is not responsible before the law. To the physician, as physician, the insane man is sick and requires treatment just like the supposed burglar with his broken leg, but in a court the existence of the disease of insanity is just as unimportant as the existence of the broken leg.

If the proved insanity is not of such a kind as is recognized by the law as an excuse, it is as though he were not insane at all.

The Parliament has authoritatively laid down what kind and degree of insanity do excuse. If a man suffer from disease of the mind to such an extent as to render

him incapable of appreciating the nature and quality of the act and of knowing that such an act was wrong, then the law says he is not to be convicted. No word of the law is to be disregarded. The accused to be acquitted must suffer from a disease of the mind not simply, but to the extent named—that is that he is rendered *incapable* of appreciating the nature of what he does—not that he does not appreciate but that he *cannot* appreciate. And the word *wrong* is not to be interpreted subjectively as it appears to the mind of the accused, for many a man does what he thinks to be right and still is a criminal.

If an insane man is not affected by his insanity to such an extent but that he is able to know what he is doing—"capable of appreciating the nature and quality of the act," and is able to know that this act is wrong, that is, contrary to the law, even if it accord with his own sense of right, he is responsible in law. Charlotte Corday, when she killed Marat, thought she was doing right—that belief would not excuse her under our law if she knew that she was doing what the law forbade.

Then there are those who suffer from a moral insanity, and they do not understand any difference between right and wrong which they are bound to respect. They are as responsible in law as Captain Kidd or any other pirate.

It is said, too, that there are those who, being insane, thoroughly know what they are doing and know that their act is against the law, but are forced on by an irresistible impulse to shoot or wound another. I once charged a jury in a murder case that the law of Canada says to those who assert that they are moved by an impulse which they cannot resist, "I shall hang up a rope before your nose and see if that will not help you to resist the impulse." No such defence avails in Canada. An English Court since that time, and, indeed, but the other day said, "Impulsive insanity is the last refuge of a hopeless defence."

I am not defending the law—I had no part in making it—I am bound to obey it, and I am simply stating it.

Again, if there be present specific delusions, the law is clear. Place the accused in the position of the delusions being true, then if the act which he does would be justified or excused, he is not guilty of a criminal act; but if not, he is. Let me illustrate. If A. suffers from the delusion that B. is seeking to kill him, and meeting B. thinks B. is about to kill him and the only way to save his own life is to shoot B., he is not criminally liable if he does shoot B. But take a case which recently occurred in Toronto. A. thought that B. was spreading the most infamous slanders about him, and, meeting him one day, he shot him. He is liable criminally. The law allows one to kill another if that be the only way to save his own life, but it does not allow the killing of a slanderer, however base.

It may look anomalous to gift in theory one who suffers from delusions with the reasoning powers of one who is wholly sane, but that is the law laid down for us all by the Parliament.

Now, medical witnesses are often fond of laying down what they think should be the law, of saying in the witness box what should be done with an insane accused. That is no part of their duty. If they are not satisfied with the law—and doctors have been girding at it for seventy years and dozens of volumes have been written about it—let them go about it in the right way to have the law changed—use influence with the Parliament, the only body which can make the change. The Court is powerless, and must lay down and apply the law as it actually exists.

The above are the chief occasions on which a medical man meets the law in insanity matters. I add just a word as to capacity to make a contract, rather for the sake of completeness than for its practical importance.

Although insane, one may make a contract binding on himself if he possesses sufficient mind to understand in

a reasonable manner the nature and quality of the act in which he is engaged, provided no imposition or fraud is practised upon him and the contract is not grossly inequitable; indeed, a very recent authority goes so far as to lay it down in broad and general terms that a contract made by a lunatic is binding upon him unless he can show that at the time of making it he was to the knowledge of the other party so insane as not to know what he was about.

THE INSANE IN JAPAN.

By Frederick Peterson, M.D.,

Professor of Psychiatry, Columbia University, New York

During a vacation spent last summer in Japan, I visited a number of institutions for the insane, and through the many courtesies of Prof. Kure and Prof. Miura of Tokyo and Prof. Imamura of Kyoto, I not only saw them under the best auspices but was furnished with much information in relation to psychiatry in Japan which I shall briefly put before you.

The medicine of ancient Japan, like its art, literature and religion, was derived from China by way of Corea. The earliest Chinese medical literature which deals in any manner with insanity dates from about 200 B. C. The earliest historical reference to insanity in Japan is contained in the law of about 702 A. D., which required the insane, epileptics, lepers, blind and crippled to be given over to certain official caretakers, who, on taking such cases into their families, were absolved from taxation and civic duties. Between these dates and for some time later Japanese physicians were guided in their study and practice wholly by Chinese medical books, in much the same manner as the Europeans for centuries acted only on the authority of Hippocrates, Galen and the Arabian writers. Insanity and epilepsy are well

described in the first Japanese book of medicine, the "Ishinho," appearing in 982 A. D. For several centuries after this, medical treatment fell chiefly into the hands of the Buddhist priests who practiced only with magic and prayer, until the period between the 17th and 19th centuries, when medicine reawakened and the Japanese physicians out-distanced in all respects their Chinese progenitors and contemporaries. The treatment of insanity during this period did not differ much from that of the more ancient day, and consisted chiefly of the sweat cure, catharsis, emetics, thermocautery with moxa, hydrotherapy, acupuncture and, at times, bloodletting. The needle and moxa as counter-irritants have for ages been favorites of both the Chinese and Japanese in all manner of diseases. Hydrotherapy described in Chinese literature as long ago as 200 B. C. has always been a preferred method of treatment among the Japanese. Its use in insanity is described in the first Japanese book of medicine already referred to (982 A. D.).

In old times the insane were for the most part kept in families, the milder cases taking part in work on the land, or in the innumerable household crafts of that people. If subject to periods of excitement mechanical restraint was used, anklets, wristlets, chains and solidly built chambers attached to the paper houses. Often in the country the patients were blistered on the soles of the feet to make them disinclined to run away.

A kind of family care grew up gradually, sometimes evolving into a colony system; and many private asylums were established long before any public asylums such as we have in the West were created.

Along in the early eighties the first public asylum in Japan was organized and established at the present capital, Tokyo. It was constructed somewhat on German lines, but with due regard to the necessities of earthquake architecture, for in a country where an earthquake is almost an every-day occurrence it is essential to build wisely. The Tokyo asylum consists of a series of

one-storied pavilions scattered in a considerable park. The German traces in construction and arrangement are, of course, due to the fact that the foremost Japanese physicians of that day had taken their training in Germany, and the medical profession was wholly directed in all its undertakings by German influence. Nowadays with several universities of their own and a goodly number of medical faculties, quite equal to any in the world, in which all of the professors and the tongue spoken are Japanese, they need not go abroad for medical study.

In the older buildings of the Tokyo asylum the usual western corridor system prevailed, with numerous single rooms, but as time went on they began gradually to remove partitions and to convert the series of single rooms into good sized dormitories. This was the more readily possible because there seems on the whole to be less excitement among the Japanese insane than among the insane of other countries. The extraordinary quietness of asylum wards in Japan has been commented upon by other foreign visitors. It doubtless depends upon that immemorial training in the repression of emotional expression which is so noticeable a feature in Japanese psychology.

In some of the newer pavilions they have European bedsteads, tables and chairs, but for the most part the furnishing is Japanese, thick mattings upon the floors, thick quilts laid upon these mattings for beds and tiny dwarf tables when such are needed, with no chairs or other furniture.

The asylum is lighted by electricity, electric lighting being a specialty of the Japanese everywhere at present, owing to unlimited waterpower in innumerable mountain torrents which have been harnessed to do this work. There is provision for the daily hot bath for every inmate according to Japanese custom, for every man, woman and child in Japan takes at least one hot bath a day, and sometimes two or three; and our Western

systems of plumbing for bath and toilet purposes have been adopted and installed. There is provision also for the prolonged bath which has so much vogue with us at present in the treatment of the insane.

Much is made of occupation. The laundry and garden work are done by inmates. There were rooms in which patients were weaving, plaiting straw, making paper envelopes and carrying on other crafts.

All the buildings were airy, neat and clean, and to me a striking feature of the care of the insane was the morale of the nursing staff. I believe such gentleness, kindness, patience and assiduous attention to the sick, could be found nowhere else, for nowhere else exists a whole race of people who never scold, quarrel or manifest impatience, but always turn a smiling face and extend a helpful hand to one another. This other fact in Japanese psychology I observed among all classes throughout my visit. It was particularly noticeable where I least expected it, among the lower classes.

The insanity clinics of the university are held here and the laboratories of the asylum are well equipped with pathological and psychological apparatus. Elaborate histories of the patients are taken, and besides the director, Prof. Kure, there are ten physicians working in the hospital, the capacity of which is about 500 beds —a capacity of one to fifty. We are lucky in New York State to have one physician to 200 patients.

There can be no overcrowding in the Tokyo asylum, for, according to law, a new patient is only admitted when there is a vacancy. An indigent patient brought before the authorities is sent at public expense to one of the seven private asylums in Tokyo if the government asylum has no bed. These seven private asylums have a capacity of about one thousand beds between them.

The method of commitment is simple. When a case of insanity develops, a member of the family reports it to the police. A doctor then goes to the house with the police officer to examine the patient and reports his

findings to the head of the police who issues an order of commitment. In the country a governor's certificate takes the place of police commitment. There is never any effort on the part of patients to escape.

The Tokyo institution has one of eleven psychiatric clinics in Japan. I believe we have not so many in the United States. There are psychiatric clinics at the three universities, Tokyo, Kyoto and Fukuoka, and at the medical schools of Okayama, Kawazawa, Nagasaki, Kyoto (two medical colleges), Nagoya, Shibu, Sendai and Osaka.

As regards the character of the cases observed in Japan, there are several interesting points. In the first case the classification approximates very closely to ours and we observe large numbers of cases of dementia præcox, manic-depressive insanity, general paresis and the like. True paranoia as we know it is a great rarity. On the other hand general paresis and dementia præcox are more common than with us. At the Tokyo asylum the proportion of cases of general paresis from the years 1887 to 1901 was 15.86 per cent.

In a country which has no opium or alcohol vice, inebriety cases are rare. Only 6.65 per cent. of the admissions of men presented mental disorder due to alcohol. A case of alcoholic insanity in women is almost unknown. Very few doctors in Japan have ever seen a case of delirium tremens. Korsakoff's psychosis has not been observed. The alcohol cases are due to saké, a mild kind of sherry-flavoured wine, derived from rice. Only the lower classes drink saké to excess, and very few of these. Temperance societies are growing rapidly in Japan. In Formosa, a province of Japan, considerable opium is used, but scarcely any in Japan itself. There are no cases of Indian hemp or cocaine inebriety. I noted a considerable number of cases of insanity wholly new to me, viz.: psychoses associated with Kakke or beri-beri. The multiple neuritis and mental symptoms made a picture something like that of Korsakoff's psy-

chosis. In our western books on nervous diseases, mental symptoms are not described at all as associated with beri-beri, but in Japan we have a beri-beri psychosis which reminds one partly of pellagrous insanity and partly of the Korsakoff syndrone.

I come now to the most interesting part of my journey of observation in Japan.

About seven miles from Kyoto, one of the ancient capitals of Japan, lies the village of Iwakura, to which one day Prof. Imamura, professor of psychiatry in the University of Kyoto, conducted me. It alone is well worth going to Japan to see. I believe I am the second Westerner who has been there, the first having been Dr. Stieda of Russia, who mentions it, and calls it a Japanese Gheel in an article on Psychiatry in Japan, in the Centralb. f. Nervenh. und Psychiatrie for 1906. Prof. Imamura has himself described it in the Transactions of the International Congress of Psychiatry, Neurology and Psychology, Amsterdam, 1907. But it deserves to be better known, for, as an ideal place for the care of the insane, it is unique, there being only one other institution for the insane that I know of that in any way embodies what should be our own ideal, as far as concerns surroundings and construction, and that is the Maison de Falret at Vanves in the outskirts of Paris.

The third daughter of the Emperor Gosanjo in the eleventh century, developed melancholia in her eighteenth year. Word was brought to the imperial household that at Iwakura was a holy fountain, the water of which was healing to mental diseases and to disorders of the eyes. The emperor's daughter was taken there nearly 900 years ago and recovered and so brought fame to the temple and the well of Iwakura, as a result of which the insane were brought there in great numbers. At first three small inns were constructed to receive them, then later tea houses and villas, and cottages sprang up in which to care for the ever-increasing influx of patients.

In the year 1889 the village had 239 houses, with 1,579 inhabitants, and up to that year one or two patients were received into each family to share in the occupations of the household, which were chiefly out-of-door employments in fields, gardens and forests.

The village lies at the foot of great hills, in a beautiful wide valley. The hills are covered with evergreen cryptomeria, pines and spruces, while the valley is cultivated, every foot of it, with rice and vegetables. Each little house has its own idyllic charm. This charm lies in its simplicity of architecture, harmony with the landscape, and in its well-studied gardens both inside the courtyard and outside around the house. Paper windows and removable paper walls ensure light and air and a practical out-of-door life night and day. From the spotless mats upon the floor, across the spotless verandahs, one looks out upon the gardens green with pines and cedars all the year round, with flowering shrubs for every month between the winters, looks out into the restful gloom of the giant cryptomeria woods on the one side, or across the valley of rice fields to the evergreen hills upon the other. There are beautiful paths and roads among these cedar forests, and several imposing temples among them.

In 1889, the Japanese government, evidently under the impression gained from a study of the asylum systems of Europe and America, came to the conclusion that their colony system that had grown up so naturally, was too far from our Western ideals, as exemplified in our colossal caravansaries for the insane, and so forbade the insane being any longer taken to the village of Iwakura. They abolished the method as probably barbarous, just as at one time they abolished cremation, having been persuaded by Europeans that it was a heathen practice, but returned to it again when they learned that cremation was the goal to which Western civilizations are tending in the method of disposal of the dead.

The result of this opposition of the government has

been to reduce at least temporarily the number of insane in the colony. It is altogether likely that as soon as the authorities learn that out of themselves they have developed through nearly a thousand years the best of all methods of caring for the insane, toward which the West itself is struggling with much difficulty, they will remove the proscription and restore Iwakura to its ancient rights and privileges under State organization and inspection. There is one retreat for about ninety patients at Iwakura built on European models under the care of physicians, to which excitable cases may be brought from the family homes in the neighbourhood.

I have already referred casually to the Maison de Falret, a French asylum in the suburbs of Paris, and in connection with the results of my visit to Japanese institutions I cannot forbear to mention it again and to say a few words about a place that is probably unknown to most of my hearers, because, after all, the chief value of any observations by a traveller must be the new knowledge, the example, the lesson or the moral that he brings home to his own people. Doctors Voisin and Falret, two specialists in psychiatry nearly one hundred years ago, purchased an estate of over sixty acres in the environs of Paris, made of it a park, and planted it well with trees and shrubs. A pretty stream courses through it. They built therein small houses or bungalows, each surrounded with high green hedges and pretty gardens with its own gateway. Now, after a hundred years it realizes their dream of what should be done for the insane. It is a large park with magnificent trees and shrubbery, divided into two halves by a farmstead group, thus making practically two parks, one for each sex, and there are twenty-seven bungalows for the isolation of one or more patients. A patient here is not only isolated from his friends, which is usually a distinct advantage, but is isolated from the insane, which is an even greater gain. I cannot take time to describe it here, but it shares with Iwakura in Japan the distinction of being

an ideal retreat from the standpoint of environment and construction for mental cases. Dr. Adolf Meyer, whom I sent to see it after my own discovery, told me it was a "dream."

We find then in Japan and in France a certain standard already attained and realized, which we might take for our own. These two places leave nothing to be desired in the way of surroundings and method of construction. We should perhaps be able to add something of our modern machinery to these plans, in the way of central heating, organization of food supply and service, telephonic intercommunication, and latter day hydrotherapy, but these are not the essentials. The essentials for the care of the curable insane are already here, and these are adequate nursing, segregation, the return to nature, the simple life, beautiful surroundings, association with normal and not insane persons, and plenty of space and opportunity for walks, for working in gardens and fields and at various arts and crafts.

Have we already drifted too far from the realization of Vanves and Iwakura, with our vast aggregations of 3,000 to 5,000 patients in one institution, with the sinking of the individual in the mass, with our appalling overcrowding, with our inferior nursing staff and insufficient medical staff, with our at best rudimentary methods of occupation, and with our immense, expensive and complicated machinery of mere support and custody?

VOLUNTARY ADMISSIONS TO THE HOSPITAL FOR INSANE, TORONTO.

J. M. Forster, Medical Superintendent.

It is quite evident, judging from recent experiences, that the time has arrived to provide for a special class of admissions in addition to those already covered by legal certification.

From time to time appeals have been made to us by the patient directly, for treatment in this hospital. Many of these instances occurred without advice, even of their family physician, and quite independently of their friends. Solely on account of the distress which their illness caused them they sought relief. It is only in the early stages of certain psychoses that any sense or realization of illness exists and it is very important, considering the ultimate welfare of the patient, that he receive the treatment at this early date, which enhances so much the chances for his recovery. In one instance a man came for treatment, after consulting his family physician, who was not at that time prepared to certify in the regular way. One can hardly estimate how much this helps the patient to recovery and how they are relieved by voluntary admission of any sense of imprisonment, which the legal process necessarily entails. What comfort it is both to patient and physician to feel that he has come seeking the help which the hospital stands ready to provide.

This would mark a new era in the treatment of mental diseases in Ontario and judging from the number who appealed to this hospital during the past year it is an evidence of the confidence which the hospital is gradually gaining in the public mind. This is very encouraging and gratifying to the medical staff and there is a general feeling that such voluntary admissions should be recognized by the statutes of Ontario for temporary treatment; at least say from 30 to 60 days.

When such a case has been received into the hospital it has been usual to exact a written statement that they sought this treatment of their own accord and left the matter of their discharge to the judgment of the medical staff, and the results have been most gratifying.

Dr. H. Clare, Assistant Superintendent, has prepared a list of the various voluntary admissions occurring in this hospital during the past official year, with short notes on each case. showing the types of mental illness that have been admitted in this way.

Voluntary Admissions.

Case 1.—A young woman came into the conference room of this hospital while the staff was assembled and gave a history of distinct mental illness extending over a period of two or three years. She said she could not do her work as well as formerly; she could not fix her attention on anything. She described impulsive outbreaks. She was suffering from auditory hallucinations. She looked thin and worried and was much under weight.

She was at once put to bed; her friends were notified and when they came they confirmed the history that she had given.

After a few months of absolute rest, with plenty of nourishment, cold shower baths and massage, she gained fifteen pounds in weight and was much improved. Her people took her away from the institution.

Case 2.—A young man who had been successful in business until 25 years of age came here for treatment. He found that he could not apply himself as formerly and during two years previous to coming here he had been unable to earn his living and had wasted, in foolish speculation, all that he had accumulated.

He came to us because he was afraid he might do harm to some people whom he said were spreading false reports about him. On examination he gave a typical history of hebephrenia; slow, gradual onset; lack of interest and indifference, auditory hallucinations with vague persecutory ideas.

Under usual routine treatment he improved and brightened up so much that his father took him away from the institution.

Case 3.—This was a periodic alcoholic, who had been drinking hard for about two weeks. He had vague ideas of suicide and came to the hospital asking that he be protected from himself. He was in a condition of depression. His tongue was coated; stomach badly out of condition; his hands were shaky; his appetite very poor

and he could not sleep. He seemed apprehensive, but had no hallucinations.

After a few days he began to clear up and was soon entirely well.

Case 4.—This woman, who had previously been a patient here two or three times came to us for treatment. She had gone into service where she had done well for about two years, but at Christmas-time, 1910, the work was hard. She became thin, lost appetite and began to worry. The day after Christmas she came to the institution two or three times and was quite excited; talked freely and said that she did not feel well. Finally about 10 o'clock at night she came into the office and asked to be allowed to remain as she felt it would not be safe to go back to her place.

After about two weeks treatment she was again able to resume her duties.

Case 5.—A woman came to the hospital; age 38 years. She said that she had contracted the alcoholic habit and that she needed help. She was afraid that she might do something that would disgrace her family. She took her medical certificates and went to her family physician; had them properly filled and returned that night to the hospital.

During the one month of treatment she gained about twelve pounds in weight. Her complexion cleared up. Stomach trouble disappeared and she said that she felt completely well.

This case was diagnosed as one of alcoholism.

Case 6.—A woman, age 55 years, who had been in this hospital many times suffering from recurrent manic excitement, came to us for treatment. When she left the institution in 1910 she promised that at the first return of any symptoms of mental trouble or nervousness she would come back.

During the summer she had been working hard nursing her boy, who had been sick for a long time. He died

Oct. 26th, 1911, and she worried a lot, and on the morning of Oct. 28th, at about 6 o'clock, she came to the hospital, saying that she knew that she could not get along at home. She was talking rapidly; not sleeping; very busy in her actions, and has since gone through the usual manic phase.

Case 7.—A man aged about 50 years, who has been in this hospital two or three times suffering from depression or melancholia, came to us. Each time when the depression comes on he develops alcoholic habits.

He was at once put to bed; given plenty of nourishment, tonic baths, etc., and responded to the treatment in about two weeks. This man has no alcoholic habits except at the time of his mental illness.

Case 8.—A young man came to this hospital who had in the north country developed the morphine habit. He came to the institution with his father and signed a request that he be kept here until we considered him well. He was anxious to break away from his old habit, and after three months' residence his father took him away from this hospital.

Case 9.—A young man, 21 years of age, came to the hospital in a confused condition. His conversation was disconnected and his mind seemed clouded. He said that he could not work because of his mental illness.

He was at once put to bed and we hoped that in a day or two he would brighten up so that we could get in touch with his relatives. The day after admission he was in a state of catatonic stupor and would not speak. We gave him nourishment by tube and he remained in this condition for over six months. He will not talk yet, but walks about and does a little work. We have not yet been able to find out who are his relatives.

In this case we considered it very fortunate that this young man reached the hospital before the stupor came on.

Case 10.—A man, aged 35 years, who had been in a sanitarium because of alcoholic habits, came to us asking for help. It was found that his was a case of Dementia Præcox, and because of the mental illness he had drifted into a great deal of trouble. He did so well in the hospital that after three months' treatment his friends took him away believing that they could take care of him. But it seemed impossible to impress upon their minds the fact that his alcoholic habits were the result of previous and serious mental illness.

Case 11.—A man of 39 years who had been in the hospital two or three times and who was suffering from Dementia Præcox came to us. He had been associating with rather fast company and had been indulging in alcoholic spirits more than was good for him. His appetite had failed. He was getting nervous, hallucinations re-appeared, and he at once returned to the institution, where, after three months he recovered and is out, doing very well at the present time.

Case 12.—A young man 29 years of age, who had a definite history of mental illness eight years ago, and who had been of the wandering type ever since, came here for treatment. During the past year he had consulted a great many physicians in Toronto, and finally came to our hospital asking to be taken care of as he feared he might do some harm to himself.

He has been diagnosed as Catatonic Dementia Præcox, but has not been here long enough yet for any improvement to show in his condition.

Case 13.—A man 35 years of age who came to the hospital, this being his fifth admission. He brought with him a letter from his family doctor, saying that he needed treatment. His was a plain case of manic excitement, but the peculiar feature of this case was that in manic excitement the patient seldom recognizes his own illness, while this man brought his letter to the institution and asked for treatment.

Case 14.—A man, aged 22 years, who had recently been a patient in the Weston Tubercular Sanitarium, became suspicious that they were poisoning him. He left there and wandered about the country a great deal and could not remain in any one place because of a fear that some one might do him harm. He also thought that they had tried to poison him at the General Hospital.

He came to this hospital and said that he knew he was not right in his mind, and asked us if we could do anything for him, and finally asked that we allow him to remain three or four days until we could determine what could be done. He has splendid insight into his own condition. He tells of the impulse to break glass and tear clothing. He tells of a feeling of double identity; he often feels that a man is standing beside him and he wants to talk to him. He sometimes feels that he can see himself walking up and down the hall.

This young man is still in the hospital and has been diagnosed as a case of early Catatonia.

Case 15.—A middle-aged man subject to periodic alcoholism came to the hospital and requested in writing that we should keep him until this habit was cured.

After two months' residence he was discharged.

These fifteen cases can be classified as follows:—

Dementia Præcox, 8.
4 Hebephrenics.
4 Catatonics.
Manic Depressive, 4.
2 in the manic state.
2 in the depressed state.
Alcoholics, 2.
Drug Habit, 1.

The two alcoholics and one drug habitue should really have been classified as mental defectives, and in our case-book conference reports, each of these cases is described as a "mental defective."

FIVE HUNDRED CONSECUTIVE ADMISSIONS TO THE HOSPITAL FOR INSANE, LONDON.

W. J. Robinson, M.D., Medical Superintendent.

The Annual Reports of our Hospitals for Insane tell us each year that a certain number of patients have been admitted, a certain number have been discharged, some have died, others have eloped, and a few have been deported, but no report, that I am familiar with, gives us the exact disposition of each year's admissions. The percentage of discharges, deaths, etc., is always compared with the admissions of the particular year under discussion, although many of the patients discharged or dead during that year were admitted long previously. It has appeared to me that it might be of some interest and value to carefully scrutinize the records of all patients who have been admitted to this hospital during the past four years, paying special attention to their family history, their alcoholic habits, the diagnosis of their disease and the final results as far as can be determined at this date.

In this article five hundred consecutive admissions beginning January 1st, 1908 and ending June 6, 1910, will be dealt with. I have selected this period for the reason that previous to that time no systematic attempt was made to obtain the life history of each patient, no conferences of the staff were held, no conference reports and no clinical notes are on record. In fact, in the majority of cases nothing was recorded except the usually incomplete and often unreliable information contained in the statement of the family physician.

In practically all the present series of cases a conference report prepared by some member of the staff, is on record. In this an earnest endeavour is made to present a true picture of the patient's life, to present all the infor-

mation possible to obtain regarding his family history, the history of previous illnesses, the history of his early life, his habits, his school career, everything, in fact, which might in any way have a bearing on the case. The report also includes voluminous bedside notes which are made by the nurse in charge during his stay in the admission hospital. These notes are very useful in shedding light on many phases of the patient's malady, which might easily escape the notice of the physician in his regular visits. They also include a complete record of his pulse, temperature, respiration, his hours of sleep, his weight at regular intervals, urinary analysis, etc., etc. The keeping of these records is of great value in the training of the nurse, especially in training the faculty of observation, and many of them are invaluable pen pictures of the patient at all stages of his illness.

With all this material at his command the trained and careful physician, who is found in all our Ontario hospitals for insane, in his final summing up of the cases is able to place on record much that must in the future prove of great value to the student of psychiatry. It will thus be seen that in regard to these cases a very considerable amount of information is available. I do not however, propose at this time to make an exhaustive analysis but will content myself with a statement of the facts of each case as well as the opinion of the conference of staff in regard to diagnosis.

Of the total 500 cases sixteen were admitted twice during the period, and thus we have to deal with only 484 individuals.

Sex:—Males, 251. Females, 233.

They are classified as follows:

199 Dementia Præcox.
60 Manic Depressive Insanity.
59 Senile and Presenile Insanity.
30 Melancholia Vera.
27 Imbecile and Defective.

20 General Paresis.
18 Epileptic Insanity.
13 Psycho-neurosis.
12 Alcoholism.
5 Exhaustive Psychosis.
3 Paranoia.
3 Huntingdon's Chorea.
4 Drug Habitue.
1 Korsakow's Psychosis.
1 Peripheral Neuritis.
1 Syphilitic Insanity.
1 Organic Brain Lesion.
27 Unclassified.

Family History.—In 153 cases, or 31 per cent., insanity is reported as having occurred in some relative. These 152 cases are classified as follows:

73 Dementia Præcox.
21 Manic Depressive Insanity.
14 Senile Insanity.
13 Melancholia Vera.
8 Imbecile and Defective.
2 General Paresis.
1 Epileptic Insanity.
3 Alcoholism.
1 True Paranoia.
3 Huntingdon's Chorea.
1 Syphilitic Insanity.
1 Drug Habitue.
2 Hysteria.
10 Unclassified.

In 40 cases, or 8.26 per cent., alcoholism in some member of the family is reported, and in seventeen of the above cases a combination of alcoholism and insanity is found.

Of these cases there are:

19 Dementia Præcox.
5 Manic Depressive Insanity.

1 Senile.
3 Melancholia Vera.
2 Imbecile or Defective.
3 General Paresis.
1 Epileptic Insanity.
2 Alcoholism.
1 Paranoia.
1 Hysteria.
2 Unclassified.

Personal History.—In fifty-seven, or 11.7 per cent. of the cases, was a history of alcoholism found. It cannot be said that all of these men were confirmed alcoholics, but their history shows that at some period of their lives they drank to excess.

They are classified as follows:

14 Dementia Præcox.
5 Manic Depressive.
3 Senile Insanity.
5 Imbecile.
9 General Paresis.
11 Alcoholism.
1 Paranoia.
2 Hysteria.
1 Korsakow's Psychosis.
1 Huntingdon's Chorea.
1 Unclassified.
4 Drug Habitue.

In only ten cases was a history of syphilis found, but as the Wassermann reaction was not taken, it is more than probable that the disease existed, unrecognized, in other cases.

These are classified as follows:

5 General Paresis.
1 Imbecile.
1 Syphilitic Insanity.
1 Paranoia.
2 Unclassified.

In the more important classes the results at this date are as follows:

Dementia Præcox—

89, or 44.5 per cent., have been discharged as recovered or improved.

13, or 6 per cent., have died.

91, or 45 per cent., are still in residence.

Manic Depressive Insanity—

50, or 83 per cent., have been discharged as recovered or improved.

2, or 3.3 per cent., have died.

7, or 11 per cent., are still in residence.

Melancholia Vera—

17, or 56 per cent., have been discharged as recovered or improved.

6, or 20 per cent., have died.

6, or 20 per cent., are still in residence.

Seniles—

14, or 23 per cent., have been discharged improved.

18, or 30 per cent., have died.

23, or 39 per cent., are still in residence.

General Paresis—

3, or 15 per cent., have been discharged improved (remission).

13, or 65 per cent., have died.

3, or 15 per cent., are still in residence.

Exhaustion Psychosis—

5, or 100 per cent., have been discharged as recovered or improved.

Alcoholism—

11, or 91 per cent., have been discharged as recovered or improved.

1, or 9 per cent., still in residence.

Summary—

233 cases, or 48 per cent., have been discharged as recovered or improved.

8 have been discharged as unimproved.

67, or 13 per cent., have died.
5 have eloped.
4 have been transferred.
5 have been deported.
162, or 33 per cent., are still in residence.

484

Conclusions.

I am well aware that conclusions of great value cannot be drawn from a limited series of cases but, nevertheless, the occurrence of insanity in almost one-third of the family histories emphasizes the important part heredity plays in the causation of insanity. The statement often made that the abuse of alcohol is one of the chief causes of insanity is scarcely borne out by these figures. We must, however, remember that the district from which our population is drawn is largely rural, and that neither syphilis nor alcoholism is found to any large extent in such a community.

It is gratifying to note that the percentage of discharges is distinctly higher than at any previous time in the history of this institution. For the past forty years the discharges, from all causes, have equalled about 42.5 per cent. of the admissions. In this series 48 per cent. have already been discharged as improved or recovered, and it is reasonable to expect over 50 per cent. will eventually be discharged, or about 10 per cent. more than the average of the past. The establishment of the Reception Hospital, which enables us to greatly increase the care and attention given to acute cases, is probably a large factor in the higher rate of discharges.

A CASE OF DEMENTIA PRAECOX PARANOIA OF LONG STANDING, WITH DELUSIONS BUT NO PERCEPTIBLE DETERIORATION OF SENSES.

By J. F. Cattermole, M.D.

Assistant Superintendent, Hospital for Insane, Penetanguishene, Ont.

Family History.—Father of patient died at the age of 67 years, does not know cause of death, was in good health until he was taken ill. No insanity on father's side to his knowledge.

Mother of patient generally healthy and lived to a good old age, no insanity on her side. No consanguinity between parents or insanity among any of his relations to his knowledge. It is said one brother is eccentric but patient denies this. The family consisted of seven sons and two daughters. One son died in infancy, one of heart failure (?) at the age of 27. One of dropsy at about 28, one of phthisis at 24, one at about 70 years, and one still living aged 84. Both sisters in good health aged 67 and 70.

Personal History.—Patient was born in 1847, commenced going to school at eight years of age, was quick at learning and generally at the head of his class, stopped going to school regularly at the age of 12, but continued to attend during the winter months until the age of 15, after which he was employed at home doing chores and helping to run the farm, had an attack of ague at 14, and sometime during childhood had measles and whooping-cough.

At the age of 23 years began farming for himself and married at 24, his first child, a girl, was born about two years after, then two years later another girl, three chil-

dren, all girls, were born subsequently, two of whom died in infancy and one lived for 21 months, but was always delicate.

When patient was working his farm he worked from 5 a.m. until dark and sometimes later, slept well and awoke refreshed and feeling fit for work. Never drank liquor, and was rather religious, had family prayers morning and night, went to church twice on Sunday also Sunday School, and attended revivals and prayer meetings whenever possible; thinks his conversion dates from the time of some revival meeting, for soon after he became a member of the Methodist Church. Patient was very fond of wife and two girls and lived very happily until the autumn of 1890, when he became suspicious of his wife and four or five of his neighbours. Carried a loaded gun to the fields with him, he claims to shoot ground hogs, also kept it in his bedroom at night, and is reported to have threatened to shoot his wife, also one of his neighbours; this he denies.

Present History.—Says his neighbours came to his place for immoral purposes with his wife, he saw each of them lying on the bed with her, and actually saw one having intercourse with her, he did not interfere, and they were not aware that he had seen them; if he had interfered it would have caused a breach of the peace, and he did not want that to happen. At another time he saw his wife and a man near the edge of the bush, he heard these people make indecent remarks and propositions to his wife, they not knowing he was near, and heard conversations and witnessed acts at distances that it was impossible to hear or see. These statements about his wife were refuted by the evidence of his daughters when the case was before the magistrate.

His neighbours and family becoming alarmed, he was brought before the magistrate, and after medical examination committed to an asylum. After three weeks' confinement he was discharged and returned home, and entered an action against the constable and some others who had

taken him before the magistrate, accusing them of false arrest. The trial, according to his statement, took place, and the court decided that he was to return to the Asylum for a year, and then get his discharge. This was in 1892 and he has been an inmate since.

From reliable sources it is alleged that what actually occurred was that when the trial of the action was in progress at Barrie, before the late Hon. Justice Rose, the patient was noticed having a small hand bag which he never let out of his possession. This was taken from him by order of the court, and found to contain a large loaded revolver, with which he boasted he intended shooting the defendants if he failed to get justice in the court. The judge ordered him into custody, dismissed the action and committed our patient to the asylum, to be detained there until the pleasure of the Lieutenant-Governor was known.

Patient admitted to asylum at the age of 45; when at home he states he weighed 160 lbs., being a man of 5 feet 8 inches. His weight now is 130 lbs. This is easily accounted for by his fear of absorbing too much poison (blue), his diet is chiefly bread and milk, and of that he eats sparingly.

Patient has been ruptured for years, and wears a truss. Has been operated on for Pyothorax recently; all organs appear normal, and he enjoys good health; is neat and clean and talks coherently and intelligently on most subjects, is interested in current events, takes exercise daily, has the freedom of the grounds, is cheerful, but never noticeably elated or depressed, no deterioration of senses is noticeable, corresponds occasionally with his wife and daughters and carries their photos about him generally on Sunday; he also reads his Bible daily. His one constant delusion is that his neighbours, acting for the English Church Tories, Popes and Joes (Jesuits), Masons and secret societies, have sworn to destroy his wife and family and prevent him having a male heir, and these organizations having influence everywhere, have ordered all asylum employees to see that his food is properly poisoned. This

delusion does not vary. About two years ago one of his daughters died of tuberculosis, and when speaking of her death, he blamed the Tories, Popes and Joes for poisoning her.

His reason for these enemies not wanting him to have a son is that he would be just like himself and would not obey Pope rule.

He has been a patient at this institution now over seven years, but was a patient at Hamilton previously for over twelve years. Shows little inclination to work, not because he lacks energy, but says he is not compelled to. He assisted the storekeeper for over a year, and did the work most efficiently, then suddenly became suspicious of someone and quit.

At irregular intervals, always on the 7th day of the month, he addresses a neatly written petition to the Superintendent, the wording of which is always the same as the following:

PENETANG ASYLUM, Dec. 7th, 1911.

DR. WILSON,
Med. Sup't.

Sir:

It is 19 years, 8 months to-day since I was put in Asylum in 1892 and 20 years 5 months on the 18th since 1891.

Please give me my discharge and liberty, clothes and statements asked for.

Stop this spite, stop feeding me this poison. Restore me my home, my civil and legal rights and all moneys and dues appertaining thereto.

This is signed by the patient.

J. C. is justly regarded as a highly interesting case, illustrating in a marked degree many of the interesting characteristics of the type to which he belongs.

CASE OF PARANOIDAL DEMENTIA PRAECOX WITH EARLY SYMPTOMS RESEMBLING THOSE OF PARESIS.

W. A. MARSHALL.

Assistant Physician, Hospital for Insane, Hamilton.

F. C.

Patient was admitted to this Hospital on Oct. 20th, 1911. He is 41 years of age, and an Englishman by birth.

Family History.—His father is living and is over 70 years of age; he is a very stout man, weighing over 300 lbs., and is possessed of a violent temper and flies into a passion on the slightest provocation; it was on this account that both he and his brother left home while very young—on several occasions before he was 15 years of age, he was put out of the house by his father, who has always used alcohol to a certain extent, and quite frequently to excess.

His mother is living, aged 71 years, and has always enjoyed good health. Patient states that there has never been any mental disease in either of his grandparents' families.

There were eleven children in the family; twins were still born, and of the four brothers, he is the only one living. His oldest brother died as the result of a gunshot wound received while a soldier in India; the other two died at the ages of seven and eleven respectively, of scarlet fever. There are five sisters, all alive and well.

Personal History.—He started to school at the age of four years and attended until he was thirteen; he was very fond of books and made good progress. From the time of leaving school till he was fifteen, he worked with his father, who was a cabinetmaker and joiner; he was always a healthy child; had measles, scarlet fever and mumps, but recovery always appeared rapid and complete. He was always very fond of music and sang

in a church choir from the time he was seven years of age.

When he was fifteen years old, he enlisted in the King's Own Yorkshire Light Infantry. On account of his ability to pick up the drill and his good averages as a marksman, he was sent to Malta six weeks afterwards, and from here was sent to India. He completed eight years in the foreign service and returned to England in 1893. The history taken in 1909 says that while in India, he got into a quarrel with another soldier, and, following a challenge by the other man, patient shot him. He was in the Hospital for two months at that time, but the details given are very meagre and as the patient disclaims any knowledge of the affair at present nothing definite can be concluded.

On returning home in 1893, he went to Scotland to fill a position as attendant in the Creighton Royal Institution, an asylum in Dumfries. He worked there for two years and then took a position with a Light and Oil Co. in Glasgow and worked with them for four years. While here, he bought a small house and one of his sisters lived with him. He gave up his position in Glasgow to assist his father in a butcher shop, which he intended to start, but had only been a few weeks at home when he found he could not get along with his father, who would be irritable and fly into violent passions one day and the next day be very sentimental, so he gave up the idea and enlisted again in the Yorkshire Light Infantry. Shortly after this, the Boer War broke out and he went out to South Africa in active service. He went right through the campaign without mishap and returned to England in January, 1903.

He then went to Brentwood as an attendant in an asylum there and it was here that he met his wife. After becoming engaged, he came to Canada in the fall of 1903, and found work as a carpenter in Toronto and subsequently sent money to his wife and she came out and they were married in Toronto. He worked there for

nearly two years; then went to manage a dairy farm for a Mr. W——— out in the country. After working here ten months, they had some apparently trivial dispute about the wood which was provided for the patient. He used some pretty strong language toward his employer and told him in plain terms what he thought of him and resigned his position. He still bears a great deal of enmity toward this man and always describes him as a "mean scoundrel," although he never mentions any circumstance which would justify such an opinion. In writing letters to his wife, he frequently mentions him as one of those who is responsible for his recent misfortunes.

The patient then went to work in a girls' college as janitor and his wife as janitress; he was here just about one year when he had some trouble with the principal, Mr. C———, who reprimanded him for some slight mistake; he became very much angered, as he did not think that he deserved it. Other circumstances cropped up which indicated that Mr. C——— was trying to give him "rotten handouts." Also, his employer was attempting to put all sorts of menial work in the way of his wife. He gives a vivid description of how he visited his former employer and told him just what kind of a man he was.

Then he came to Hamilton and obtained work in a large manufacturing house and was put in charge of a part of the shipping department. At the same time he was made choir-master in St. M—— Church. Through the influence of one of his friends, he got a better position in an elevator works. He was put in charge of the upper two floors and had charge of all the electrical fittings, and as he was industrious, his services were satisfactory to the company. After he had worked here for two years, his employers thought that there was a change in his usual manner. His physician states that he was apparently run down. Data as to his actions at this time are very scant, but the certificates of insanity state that he bought a hatchet and threatened to kill one of the men at the shop where he was working. His actions

were, at any rate, of such a threatening character that he was committed to the jail here. He still bears great enmity toward the manager, Mr. S———. He was examined and sent up to this Institution on April 23rd, 1909.

Notes from his clinical record on April 23rd, 1909:— "He was quite excited, tearing bed-clothes, his night-shirt, etc. He would turn his bed upside down and knocked quite a bit of plaster off the wall. Hallucinations were prominent." He had no insight into his condition and was very angry at his detention. On one occasion he worked a leg off the bed and attacking the attendant who entered the room with his dinner, cut him badly on the forehead. After being here some weeks, this excited condition passed off and the patient became well behaved and a fair worker. His mental condition at this time, recorded in this clinical record is as follows:—

"Hallucinations and delusions were very prominent on admission. Every night patient would see his wife, who came through the grating of his window. He would talk to her. A train would frequently start from just outside his window. He had frogs in his room, etc. At the present time, he positively denies all these, attempting to explain some as real facts. Attention is easily gained, maintained and directed. His fondness of talking about himself and his affairs may, after a lengthy discussion, lead him to forget the subject in question and wander in another line, explaining in detail. He did the 6-100 test perfectly and appears to be fair at figures. Memory is exceptionally good for remote events. He gives his dates quite clearly, of his different trips. For recent events, memory is somewhat poor. He remembers going to gaol, coming here, etc., but his actions are not remembered. It appears that in his attempt to convince everyone around of his sanity, he simply refuses to show any acknowledgement of some of these insane acts. He is perfectly oriented as to time, place and person. He shows no insight whatever; says he was arrested at the instance of crazy S———, manager of the elevator works and

that he was transferred from the gaol here because in his attempt to resist, he attacked the attendant. He says that the gaol physician and the gaolers said he was not insane.

Emotional Field.—Since he has quieted down, he has written his wife regularly. He writes very nice letters, showing that he is greatly devoted to her. He shows no mannerisms, negativisms or stereotyped movements. He takes a great pride in referring to his various accomplishments—singing for example; how he was in demand and the choruses he has led; the immense scores he and his team have made at cricket; how when he was made known to the heads of the elevator works, he was offered a position to come to work when he liked at any time, from one to six months and to set his own salary—"Of course, using my best judgment," he said. He is very proud of talking of himself and his journeys.

He tells now of a device which enables him to sing. He puts a needle in the side of his cheek, resting on the gums; this he says, when vibrations strike this point, gives the voice a finer quality.

Physical Examination.—Rather short, of medium build, normal weight, about 140 lbs.; present weight, 146 lbs.; height, 5 feet, 6 inches; head measurements, O. F. 19, Bi. P. 15, Bi. T. 12.

Fair complexion; hair black and short with a tendency to be thin in front; a light-coloured moustache.

Ears, normal; lobules non-adherent; hearing good.

Eyes.—Iris, blue. Just above and to the outside of pupil in left eye is a fairly large patch of brownish pigment, which he says, is congenital. Both pupils react normally to light and accommodation; sight is good.

Nose.—Slight deviation to left side and a prominent bump on the ridge. This, he says, comes from a smashed nose, the result of a fight at Quetta, India.

Mouth.—Lower teeth in good condition; upper ones are nearly all out. The remainder are badly decayed.

He wears a plate in upper jaw. Palate—rather high arched. Mucous membrane—healthy.

A small scar about middle of neck (over sterno-mastoid muscle) on right side. He does not remember what it was.

Gastro Intestinal Tract.—Appetite good; bowels usually regular, tendency to be costive.

Lungs.—Negative.

Abdomen.—Negative.

No evidence of lues.

Reflexes.—Normal.

Hand-writing.—Good, neat and legible.

Muscular development.—Good. His grasp is strong. Organic reflex is present. No tremor.

June 7th, 1910.—Since August last, patient has been quiet and well conducted. He has gradually improved physically and has taken on considerable flesh, in fact is stouter now than at any period in his life. There seems to be considerable mental dulling. He has been well conducted and an excellent worker under supervision. There is a suspicion that he suffers from some speech defect when he slurs his words and has great difficulty in enunciating test words and phrases, but this, at other periods, does not seem so evident. At times he seems quite dull and will sit in his chair and fall asleep. His facial expression at times seems lacking and the lines of expression appear to be slowly disappearing. He has been so well conducted and such a good worker that it was thought advisable to allow him to go out with his wife on trial, as their circumstances are such that he will be employed at the home where she is living. There is still a suspicion that patient is suffering from General Paralysis, and that at present he is undergoing a remission of the disease.

* * * * * * * *

After leaving here, patient worked at home in the garden all summer. He tried to get work, such as he was

accustomed to do, but failed, and says that he then took anything he could and worked as a common labourer in a wood yard for some months, but had to quit on account of sickness. Some time in August, he began work in the City Hospital as orderly.

Everything went along smoothly until the 26th of September, when a new orderly, by the name of A———, came to work at the Hospital. The patient takes great pleasure in showing how much superior he was to the other man on the work, having had experience in this line in an asylum in England. The new orderly was on at night while he was on duty during the day, and he says that the new man began to impose on him and would not clean up the bed pans after they were used, and, therefore, patient would have to clean them when he came on duty in the morning. He describes the other man as evil looking and ignorant, and says that he spoke and looked like a tramp. There was an evil look in his eyes which were bleary and repelled one from him; he seemed to take a violent dislike to him from first acquaintance and relates how inferior his reports were to his own. He always used the symbol (℥) for ounces, which the other man did not, and printed the names of the patients, which A——— could not do and never made mistakes in spelling. He also used the Roman numerals.

On the third morning after the new orderly came, patient came down early and took the man in and showed him the pans and says he sternly reproved him and ordered him to clean them, however, when his back was turned, the man went off duty and retired to bed. The patient says that he cleaned the pans himself and at dinner time went up to his room to clean his teeth (both he and A——— had been put into the same room for the time being), and when he got up to the room, he found that A——— had barred the door; the patient says he was always a man of great strength, so he put his shoulder to the door and succeeded in opening it. He was very much angered about this occurrence. When he got in,

he found A——— lying with his face to the wall, apparently sleeping. He got his tooth brush and went down to the bathroom and cleaned his teeth. When he came back, he found A——— awake and looking at him with a very insulting smile on his face. He thought of the two dirty tricks which the man had played on him and he fairly boiled. Walking over to the bed, he started hammering the man's face. He thinks he struck the man 72 times. His face was all covered with blood and swollen, but he kept on pounding. He says he cut him up something awful. He then carried his trunk out of the room; it was very heavy, he said, and another man would not have tried it.

The man reported him to Dr. Langrill and he was called in and asked why he did not report the man instead of pounding him. He was still angry and said he would not have got any good from that. He was brought up in the army, where, if any man did you a dirty trick, you took it out of him. He was taken to the police court and the magistrate sentenced him to two months in gaol. He has since considered Dr. Langrill one of his enemies and a man who gave him a "dirty hand out." He has worked the Medical Superintendent of the Asylum in as one of his enemies. He says if he had not come down to the gaol, his two months would have been up and he would have been at liberty.

He was admitted here on October 20th, 1911, and since then has submitted quietly to the discipline of the hospital and has not been violent.

Present Mental Status.—There are no disturbances in the process of perception. Hallucinations and illusions, which were prominent on his admission over two years ago, are not present. He knows where he is and why, although he believes he is detained unjustly and understands all questions put to him. He knows and recognizes all the attendants and many of the patients on the hall.

His attention is fairly easily gained, but it is difficult to direct it along definite lines. His answers to questions are

filled with descriptions of unimportant details which, if he is left alone, completely obliterate the goal idea towards which he first started. His attention needs to be constantly directed to gain any information of any event of his life.

In simple arithmetical tests, he makes many mistakes. He is also slow in giving answers, showing that it is a considerable effort. He did the three word test twice correctly out of three times, but it was with great difficulty that he remembered the words one minute later.

The patient has an accurate and well ordered remembrance of his life previous to his illness in 1909. His experiences since that time seem to have made no impression on his mind, with the exception of his experience at the City Hospital. He has no memory of the lapse of time. He has no accurate knowledge of the length of time he has been in the Institution, always believing it to be much shorter than it really is. He allows himself to be corrected after much reasoning, but the next day has forgotten again.

Patient shows no insight into his condition. He refuses to admit that he has ever been unbalanced mentally. A prominent feature in his case is his pronounced egoism. He believes that he has shown great ability as a marksman, cricketer, musician or in anything he has ever taken up. In his conversation, he is always producing examples of his excellence. His ideas do not border on the impossible and it is probable that he may have at one time shown some degree of proficiency in these things. He does not, however, recognize his inability at present. He was given an opportunity on his own request to sing in the choir here, and the choir-master said that he believed that he had at one time known something about music but his voice has now gone. He made himself such a nuisance with interruptions and suggestions, that he was sent back to the hall. After making so many mistakes in the arithmetical tests, he immediately afterwards sat

down and wrote a letter to his wife boasting how he had done all the tests perfectly.

The patient has a great many delusions concerning his imaginary persecution at the hospital. He was not in fear of his persecutor nor did he believe he was exercising any mysterious influence. He attributed every act on the part of the other man as an attempt to insult him. He cannot be persuaded that he did anything unlawful in treating the man the way he did. He believes that he took the only way of getting relief. He affirms that he is not sorry and would do the same thing again. Many of his delusions concerning his treatment by the manager of the elevator works, which took place before his admission here in 1909, have faded. He still bears great enmity towards him and calls him "the dirty scoundrel" who was responsible for all his subsequent misfortune. The following letter shows many of the features of his mental condition:—

"My Dear Wife:—

"I was very glad to receive your letter to-day. Mr. S——— gave it to me as soon as I got into the dining-room for dinner. I don't think I shall be long here. You see, I got two months for that affair at the hospital and I cannot understand why they should keep me anywhere except for that time. I certainly am perfectly right in every little particle of my anatomy. In all my family and in my grandfather's and grandmother's family, never such a thing was known as an imbecile. My granddad lived to be 104 years of age and grannie lived to be 99 years and over. My parents are alive and well now, and my father still working at his trade, though he is somewhere about 76 years. The man who seems to think there is anything wrong with either your family or *mine* is,—well, something I cannot give a name to.

I would like you to write to my parents, but I think it would not be well to mention that I am here. It would pain my father and mother and sisters and I would not like them to hear of it.

I am sorry about your being so tired, Annie, with so much work to do. We have been very unfortunate since we left Guelph—left it not in an ordinary way, but through the dirty actions of A. C. F———, both in Toronto and Guelph. May God's curse fall on him at the Judgment Day. Still, we will get a home together in the future. I intend to do it and so I know such is your longing. There's just two men I have to blame for setting me back, F——— and W———. And now, we will put all the struggles we have had out of sight. They are not worth thinking of and would certainly never have occurred to us if I had not come to Canada first.

I would like you to know that last Friday, Dr. M——, after examination of both body and counting backwards from 200 deducting 8 at a time, which I did very easily, and then counting same way, deducting 7 at a time, which I just ran away with. As he went away, I told him how I had passed in the Parliament Buildings in Bombay, the highest standard in the Hindustani language, for which I received 500 rupees and the "Bagh o' Bahar," a beautiful gold decorated book I read from and translated into English.

Dr. E—— told me last Friday that I was going home. I expect you will have to come for me. With all my love to you and our children and hoping we shall make our future a satisfaction to us and ours.

Yours affectionately,

FRED."

The patient has seemingly a tender and affectionate regard for his family. He frequently asks about his son and is anxious to see him. He requested that his parents be not notified of his condition lest it should worry them.

He is very anxious to go out to work for his family. On being discharged from the institution over a year ago, he looked for some time for respectable work, such as he had been accustomed to do. On not being able to get it he worked at anything he could get, and was working regularly at the time of his arrest.

The patient has never been addicted to the use of alcohol or drugs. He gives a history of having had syphilis, which he contracted while in India. The patient declares he received the infection in some cut received during a fight. He has a peculiar hesitating manner in speaking. These and other features of the case on his first admission, led to a suspicion that he was suffering from General Paralysis and at that time the diagnosis was left open.

There are present now none of the physical signs of paresis. The pupils are active, responding well to light and for accommodation. Romberg's sign is not present. The patellar reflex is normal. He writes a nice plain hand and his sentences are well put together. He pronounces clearly such difficult combinations of words as "Massachusetts Royal Artillery," "Methodist Episcopal," etc.

He was presented at the staff conference on December 6th, 1911, and unanimously diagnosed as a case of dementia præcox of the paranoidal form.

A COMMON SKIN DISEASE SEEN IN THE HOSPITALS FOR THE INSANE—PSORIASIS.

By C. M. Crawford, M.D.

Assistant Physician, Hospital for the Insane, Brockville.

The value of our Hospitals for the Insane as clinics for skin diseases is not adequately appreciated by the profession at large or by the medical students of our leading universities. In the writer's short experience of some nineteen months spent in two of these institutions, he has seen, he believes, typical cases of practically all the commoner skin diseases mentioned in the literature, besides a few of the rarer ones such as cornu cutaneum and pemphigus. In view of this fact, there-

fore, no apology is required for taking psoriasis as a subject for an article in the Bulletin.

In looking over the literature in search of information on the subject, the writer was struck with the fact that in the various medical journals for the last year such information was conspicuous by its absence. Whether this means that the interest of the profession is turned into other channels or that dermatologists are not as much to the fore as they formerly were owing to the rarer occurrence of skin diseases is not for us to say. At any rate, outside of the *New York Medical Record* little information on the subject could be obtained.

The following article does not claim to be original in any respect. It merely aims at epitomizing as briefly as possible the present state of medical knowledge regarding psoriasis. Two plates are shown, one representing an ordinary and the other a very severe type of the disease. Both are taken from the wards of the Eastern Hospital.

Psoriasis.

Definition.—Psoriasis is a chronic inflammatory dermatosis characterized by the appearance of roundish, slightly raised circumscribed patches of various sizes with infiltrated bases of a red or brownish red colour and covered with whitish or greyish mother-of-pearl-coloured scales. The disease varies greatly in intensity, in some cases presenting merely a few small scattered lesions, in other cases showing up as large coalescing patches, covering a very large portion of the body.

Symptomatology.—The elementary lesions of this disease are small red papules, which are quickly topped by dry, adherent, whitish scales. The papule spreads at the border with the formation of a smaller or larger patch, sharply defined from the surrounding tissues. The larger patches are formed not from the coalescence of the elementary papules but by their gradual enlargement.

Psoriasis differs from other skin diseases in presenting one type of lesion only. It is never vesicular or pustular

and never exhibits any degree of moisture throughout its course. It has only a dry, inflammatory base and whitish adherent scales. When the scales are gently rubbed off with the finger nail, very often there is left a small bleeding point which is the top of the somewhat enlarged papilla. This is often mentioned as one of the diagnostic signs of the disease. The scales may be in one or several layers and as a rule are whitish. The color, however, may be altered to a yellowish tint by the admixture with sweat or to a brown or black due to contamination with dirt. As a rule the scales do not cover the entire base but leave a small rim of inflammatory surface on the outside. Where the patches are extensive, the skin becomes infiltrated and inelastic, and in parts subject to considerable movement, very often deep, painful fissures appear.

Psoriasis is divided into several varieties, according to the size and appearance of the lesions. It may remain papular all through its course, when it is given the name of Psoriasis Punctata. The lesions may become larger, running from a quarter of an inch to a half inch in diameter, when it is called Psoriasis Guttata. They may reach the size of a coin, when it is called Psoriasis Nummularis. Then, again, the lesions may become much larger, clear up in the centre and yet extend at the periphery, meeting similar lesions and giving the appearance of gyrate or polycyclic figures, a condition called Psoriasis Gyrata.

Psoriasis has a predilection for certain areas of the body. This is so characteristic of the disease as to constitute an important diagnostic sign. It is found most commonly on the extensor surfaces of the limbs and upon the scalp. In the arm, it is commonly seen below the olecranon, and in the leg below the patella. It is also found quite frequently on the back over the lower lumbar vertebrae and the sacrum. The hands, feet and face are very seldom involved, although it may extend from the scalp for a short distance beyond the hair line in front

and behind. Another frequent site of the disease is over the sternum. In very severe cases the characteristic distribution is departed from, and the lesions may be found on every part of the body. In a few cases, it has been seen to develop on the site of former injuries, over scars, tattoo marks, and in parts subject to pressure, such as the waist line in women, and on the fingers under rings. As a rule the disease does not affect mucous membranes, although two German observers have reported two such cases. On the scalp, the disease shows considerable scaling, the scales as a rule being dry and white, though occasionally greasy and yellowish. They are generally, as on the body, found in roundish, circumscribed patches. As a rule the growth of the hair is very slightly interfered with, although it is dry and lustreless. Occasionally the disease appears under the nails when they become dry and brittle. As a rule the subjective symptoms of psoriasis are very slight. When the condition is of moderate severity, there may be some itching, stiffness and feeling of tension of the surface of the skin, and when fissures form these are very painful.

Psoriasis is essentially chronic in its course. Under suitable treatment, it may clear up for months and even years, but it is almost sure to recur sooner or later. The patches clear first in the centre, the scaling becoming less, the infiltration gradually disappearing and the parts returning practically to their original condition, with the exception of a slight pigmentation. In a few cases certain sequelæ have been noticed such as the development of simple papillary growths, or as in some other skin diseases the formation of epitheliomata.

Etiology.—Nothing really definite is known regarding the cause. The disease is a little more frequent in males than in females, and it is a disease of youth and early adult life. As a rule it is worse in fall and winter than in summer, although this order may be reversed.

The importance which heredity has in the causation is very differently estimated by various authorities, Erasmus

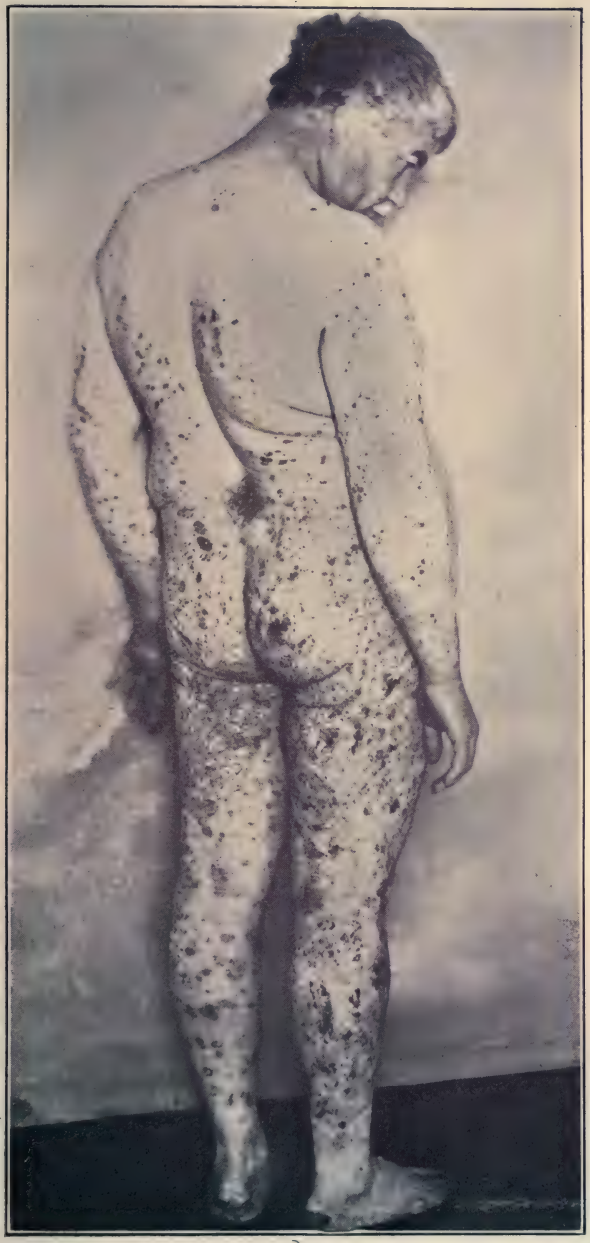
Wilson giving it as high as 30 per cent. Certain exciting causes occasionally active are: a rheumatic tendency, gout, gastro-intestinal disturbances, alcoholism and pregnancy. Very often the patient enjoys robust health and the dermatosis is the only condition present.

Unna considered the condition to be caused by a parasitic organism which he called the Morococcus, and Lang considered it due to an organism called the Epidermophyton. The Morococcus has been shown to be nothing more nor less than the Staphylococcus albus, while the Epidermophyton has proved to be an eleidin granule.

Pathology.—A difference of opinion exists as to whether the inflammation starts in the corium or in the deeper layers of the epidermis, although later opinions favor the latter view. The stratum corneum is considerably thickened, the cells being separated more or less from each other and the spaces being filled up with debris, micro-organisms and air. It is this admixture with air which causes the scales to have their characteristic silvery appearance. Cornification is defective and the stratum granulosum is either thickened, thinned or absent altogether. The cells of the rete malpighii show active proliferation and migrate into the corium. There is an overgrowth of the papillæ together with an enlargement downward and laterally of the inter-papillary processes. The blood vessels of the corium are dilated and congested and there is a cellular infiltration of the surrounding tissues with leucocytes. There is an absence of keratohyalin and eleidin granules.

Diagnosis and Prognosis.—The diagnosis is made on the following points: the distribution of the lesions, their roundish, sharply defined character, the dry, silvery adherent scales on an inflammatory base and the tendency to recur.

As a rule, unless of very long standing, or of great severity an attack can be cured for the time being, but the condition is almost certain to recur in the course of a few months or years.



DIFFERENTIAL DIAGNOSIS.

Syphilis.	*Psoriasis.*
1. Mucous patches and condylomata present.	1. Absent.
2. No itching.	2. Occasionally itching.
3. Scales brownish with ham-colored base.	3. Scales white and shiny on a red base.
4. Commonly attacks face, palms and soles.	4. Extensor surfaces and scalp most commonly.
5. History of stages of disease.	5. History of a long-standing eruption.
6. Mercury and potassium iodide specific.	6. Arsenic almost a specific

Eczema.	*Psoriasis.*
1. Weeping at some stage.	1. Dry throughout.
2. Flexor surfaces especially, also hands and face.	2. Extensor surfaces, rarely hands or face.
3. Itchy always.	3. Not itchy as a rule, except in gouty cases.
4. Patches diffuse gradually fading into healthy skin.	4. Patches sharply defined.
5. No silvery scales.	5. Silvery scales present.
6. No bleeding points.	6. Bleeding points on removal of scales.

Seborrhoea sicca.	*Psoriasis.*
1. Scales greasy to touch and on removal leave a white surface.	1. Scales dry, and on removal leave a red bleeding base.
2. Scales consist of sebum.	2. Scales consist of epidermic cells.
3. Confined to the scalp.	3. Passes below hair line in front and behind, and found on other parts of the body.
4. Hair is lustreless and falls out in large quantities.	4. Hair becomes dry but does not fall out.

TREATMENT:

(*a*) *General.*—If any disturbance of the general health co-exists with the psoriasis, an effort should be made to correct it. If there is a gouty or rheumatic tendency, the exhibition of the alkalies, salicylates, diuretics or colchicum will be of use. The bowels should be kept working freely by the use of mercurials, mineral waters, epsom or rochelle salts. In debilitated and anæmic cases, cod liver oil, iron and hypophosphites will be found useful. The diet should be carefully regulated and according to McIntosh, of Boston, meat should be excluded as being unfavorable to the progress of the cure. One should not fail to counsel hygienic living, proper exercise, frequent warm bathing, massage, and the avoidance of an excess of alcohol, tobacco, tea or coffee.

(*b*) *Specific.*—The specific treatment of psoriasis is both internal and external. The internal treatment consists in the use of arsenic in some form, preferably in that of Fowler's solution, the liquor potassii arsenitis. A useful prescription containing this drug is as follows:

R

Liq. potas. arsenit. .....drachms 2
Vini Ferri .....ounces 4 M

Sig.—Teaspoonful three times a day after meals.

This corresponds to a dosage of four minims which is increased one minim every three days until the limit of tolerance is reached. In cases where the stomach does not tolerate arsenic, Cocks of New York advises hypodermic injections twice weekly of arsenic iodide, ten minims of one per cent. aqueous solution. Fowler's solution may also be used hypodermically, starting with three minims, diluted four or five times with sterile water, three times a day. Pusey of Chicago advises sodium cacodylate in doses of one-half to one and one-half grains

three times a day, claiming that it does not so readily disturb the digestion. The arsenic treatment should be kept up for some time after the scales have disappeared and the parts have returned to their normal appearance.

Arsenic, however, is contra-indicated in acute and inflammatory forms of psoriasis. Another drug which has been recommended, but which is not very satisfactory, is potassium iodide in heroic doses. Other remedies which have enjoyed a fleeting popularity are oil of turpentine, tar, carbolic acid, salicin, tincture of cantharides and thyroid extract. In the acute cases of psoriasis, wine of antimony in doses of five to ten minims, three times a day is sometimes useful.

The external treatment is directed first of all towards removing the scales which are so abundant over the psoriatic patches. This is accomplished by daily warm baths of ten to thirty minutes duration with the free use of tincture of green soap. The baths are rendered alkaline by the addition of borax, sodium bicarbonate or ammonium chloride, two to six ounces to a thirty gallon bath. The scales may then be easily rubbed off with a nail brush. They may also be removed by the application of salicylic acid, twenty to thirty grains to the ounce of vaseline, or by covering with a tightly fitting rubber cloth, so that they become softened by the perspiration.

Upon the removal of the scales, a stimulating ointment is applied of which the main constituent is chrysarobin. A very good prescription is the following:

R

Salicylic acid	grains 1
Green soap	drachms 2
Chrysarobin	drachms 2
Oleum Rusci	drachm 1
Vaseline	ounces 2 M

Sig.—Apply to the patches with a small brush twice daily.

This is applied to the affected areas for four or six days after which the patient takes daily hot baths for two or three days, when the ointment is again resumed.

Wherever chrysarobin comes in contact with the clothing, it stains it brown, and hence, in order to prevent this, the following method of application is sometimes made use of. A drachm of chrysarobin is added to an ounce of chloroform and thoroughly mixed. A portion will dissolve and a portion will remain suspended for a short time in the liquid. It is then painted on the lesions. The chloroform evaporates and leaves a fine layer of chrysarobin on the surface, which is then covered with a layer of collodion, fixing it and preventing it from coming in contact with the under-clothing.

On account of its staining properties chrysarobin cannot be used above the clavicle and hence, on the scalp, ammoniated mercury ointment combined with salicylic acid in the strength of one drachm of the ointment with ten to twenty grains of salicylic acid to the ounce of vaseline is used. The scalp should be thoroughly cleansed of its scales with soap and water first and then the ointment well rubbed into the patches. Other drugs used locally are pyrogallic acid, twenty to sixty grains to the ounce, tar, betanaphthol and sulphur.

A very effective method of treatment of old chronic cases consists in the use of the x-rays. A tube of medium vacuum is used, and care is taken to stop short of producing any severe grade of dermatitis. The rays are of medium penetration, the equivalent spark in the air being four inches. The time exposure will be about ten to fifteen minutes of the static machine weekly.

A CASE OF ANEURYSM, ASSOCIATED WITH GENERAL PARESIS.

C. S. McVicar, M.B.

Pathologist to Toronto Hospital for Insane.
Assistant in Clinical Medicine, University of Toronto.

Patient—H. A. W.

Aged 44. Plumber. Worked as a gasfitter since eighteen years of age. Married first wife when twenty-one years of age, and had a family of five healthy children. First wife died at birth of youngest child—now aged thirteen. Married again at thirty-eight years of age. There were no children by second marriage, but patient thinks there were three or four miscarriages. His father is dead; cause not given. Mother, five brothers and five sisters are alive and well. Has used tobacco to excess and liquor moderately. No definite luetic history was obtained. He was passed for Life Insurance in May, 1910. Admitted to the Hospital for Insane September 13th, 1910. His certificates state that he had recently experienced a change of disposition. His memory for recent events had become poor. He was very irritable at times, and had once attempted to choke his wife. He appeared confused, and one day had started to work at 5 a.m., as usual, but did not arrive at work and was found late that night fourteen miles from his employment trying to break into an out-house at a railway station. He could remember nothing that had happened during that day. He had aural hallucinations and said that his wife was trying to poison him. He had begun to use foul and profane language which was contrary to his habit. It had been noticed that his gait had become unsteady—that he had loss of knee jerks—that his speech was hesitating and that difficult words were slurred.

His wife stated that about two years ago, after eating a hearty meal, he had become very ill and vomited.

The next morning he had some loss of power in the left hand—accompanied by numbness and tingling, while the tips of the fingers seemed to burn. He dragged his left foot a little. He could see in front of him but could not see to the left. For a few weeks after this he acted like a drunken man, staggering and wandering about aimlessly, but eventually improved and returned to work.

He got along fairly well until about a year ago when he would get up in the night, dress, and go out of the house. His wife would follow him and by humouring him a little would succeed in getting him back to the house. He had an idea that poison was being put in his food, and he refused to eat. His wife thought that these were simply manifestations of ill-temper. He would put things down and in five minutes would have no recollection of where he put them. He complained of severe headaches, and at times would go blind for a period of ten minutes. Had violent outbursts of temper without any apparent cause, and several times assaulted his wife, and the next day would have no recollection of the incident. On one occasion he wandered away as far as East York and was away all day and night, and was finally found breaking into a railway freight carriage. That same day he had lost all control of his bowels and bladder. He spent his money quite recklessly and his wife could not find out where it was going. He would not speak when spoken to until five minutes later. He was quite hypochondriacal and took many patent medicines for his bodily ills. He would sit and stare at one object for hours at a time.

Sept. 16.—Since admission the headaches have improved to a great extent. His blood pressure has been taken and found to be 230. He is still irritable and depressed. No delusions have been elaborated since he came to the hospital, and no hallucinations.

On September 19th a lumbar puncture was made which gave a negative result to the Noguchi and ammonium-sulphate tests for globulin, and a cell count of 2 per C.M.M.

Another lumbar puncture on September 29th gave the same result.

On October 18th the following note was made:—Examination of chest:

Inspection.—Marked systolic pulsation on the right side of the neck. This is seen to a lesser extent in the episternal notch. Left side of neck is free from pulsations. Apex beat is diffused through the 6th intercostal space from the parasternal line to slightly beyond the left M. line. There is a slight pulsation in the 2nd right intercostal space near the margin of the sternum. There are several areas on the lower part of the chest, and over the left side where the skin is slightly raised, and is either purplish red or scarlet in colour. Expansion equal and moderate.

Palpation.—Apex beat diffuse and heaving. Pulsation in neck easily felt. There is an elastic tumour felt in the episternal notch which has an expansile systolic pulsation.

Percussion.—Upper border of heart at 4th rib in parasternal line. Left border quarter inch outside the mammary line in the 6th interspace. Right border at right margin of the sternum. Superficial cardiac dullness from right border at 5th rib to apex beat.

Auscultation.—Mitral sounds negative. Second aortic sound is accentuated with a ringing quality. Over the episternal notch the sound has the same ringing quality. Pulmonary second sound is accentuated. Tricuspid sounds negative.

Pulse.—Artery thickened and somewhat tortuous but not hardened. Pulse equal in radials when lying down. After sitting up for some time there is some weakening of the right radial pulse. Systolic blood pressure 230 M.M.

Dec. 20th.—This patient is in a depressed condition most of the time; very slow in his movements, and sluggish in appearance. Suffers from constipation and gets dizzy; feeling faint and finding it hard to get his breath. Takes his food regularly, and sleeps fairly well.

Dec. 27th.—Has been very weak for the past forty-eight hours. The attack came on two day ago with profuse sweating followed by blindness and a semi-conscious state; lasting over two hours. He slept the balance of the night, and the next morning had a similar attack. He is more quiet this a.m. Complains of thirst. R. 20 P. irregular at 6 p.m. Holds head to left side as if powerless, and eyes are apparently sightless.

Dec. 28th.—Very weak all day. Difficulty in breathing. Eyesight poor.

Jan. 1st.—Weak and helpless. Eyesight poor. Has incontinence of urine.

Jan. 10th.—Lumbar puncture made to-day when the Noguchi and ammonium-sulphate tests for globulin were both marked, and there was a cell count of 10 per C.M.M. Examination of the eyes showed normal muscular action. Pupils irregular, the left is large; both react sluggishly to light. The arteries of both discs are small in comparison to the veins, and where an artery crosses a vein it compresses it considerably.

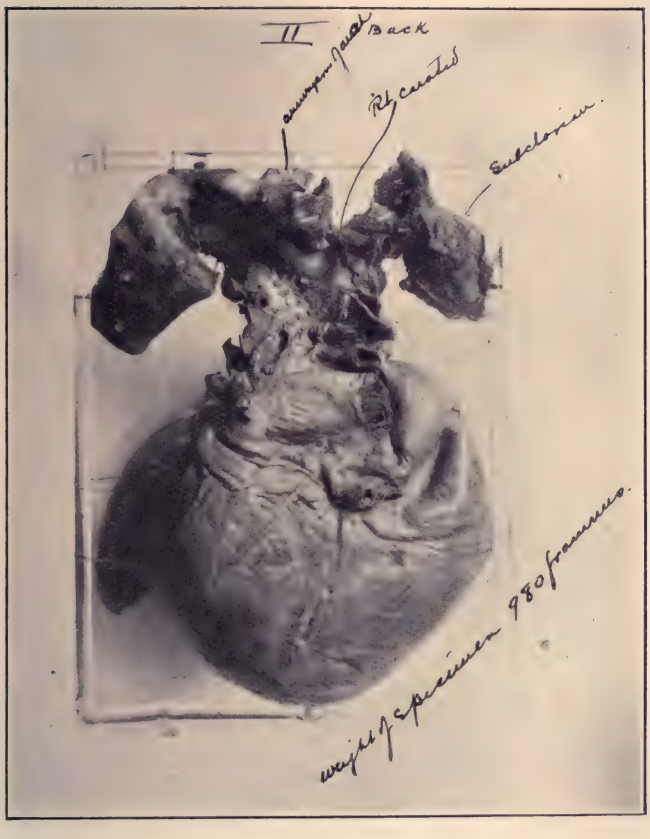
Jan. 29th.—Patient is confined to bed on account of weakness and dizziness.

Feb. 15th.—Examination of chest:

Inspection.—Pulsation in right side of neck less marked, but still more marked than on the left side. Apex beat diffuse, heaving 1 inch outside the mammary line in 5th space. The jugulars are engorged constantly. There is a marked cyanosis. He sweats profusely at times and shows some dyspnœa on exertion.

Palpation.—An elastic tumour is felt in the episternal area, with slight expansile pulsation. The radials are synchronous and equal in force.

Percussion.—There is an area of dullness extending 2 inches to the right of the midsternal line in the 1st and 2nd spaces, and 1½ inches to the right in the 4th space. Dullness is demonstrable 1½ inches to the left of the midsternal line in the 1st and 2nd left spaces;


II
Back
occipito-parietal
Rt carotid
Subclavian
weight of specimen 980 grammes.

reaches the nipple line in the 4th space and is in the left anterior axillary line in the 5th and 6th spaces.

Auscultation.—The first sound in the auriculo-ventricular areas is muffled. The second sound is distinct. A soft systolic murmur is heard best in the 2nd left space in the parasternal line, and with less intensity over the whole area of the base. The second sound is very well marked in the aortic area, but has lost its ringing quality.

Blood pressure.—Systolic, 115; Diastolic, 70.

There is no cough, no tracheal tugging, no difficulty in swallowing, and no hoarseness. He complains of pain in the head, and of inability to see well.

March 12th.—Patient complained to the night nurse of pain in the stomach. On examination his extremities were cold, his radial pulse absent, and there was a general cyanotic condition of his whole body. There was an œdematous condition of the face.

March 14th.—Patient died, and at autopsy the following notes were made:

Dura mater.—A few adhesions over the vertex.

Pia-arachnoid.—Cloudy and thickened.

Arteries at base of brain.—Show moderate sclerosis. The basilar is completely thrombosed. The cerebral vessels are all congested.

Weight of brain.—1,300 grammes.

Cerebrum.—No marked change in convolutions.

Cerebellum.—Shows a flattening of the posterior part of the right lobe.

Liver.—Weight of liver 1,540 grammes. The liver extends a distance of 3 inches below the costal margin at the mammary line. The surface is smooth, uniform, somewhat mottled; showing patches of greyish brown with dark brown border.

Pericardium.—Contains a small amount of fat. Pericardial cavity has a small quantity of clear fluid.

Heart.—On opening the thoracic cavity the left margin of the heart is seen in the anterior axillary line at the level of the 6th space. The right border is 2 inches to

the right of the sternum. The anterior mediastinum from the 3rd interspace upward is occupied by a mass which reaches 2 inches to the right of the midsternal line and 1½ inches to the left. The right auricle is tense and fluctuates, being enormously distended with dark fluid blood. The small veins cut in opening the thorax all exude purplish blood very freely, and the cervical veins are markedly congested. The left ventricle is very large and firm. The heart and the thoracic portion of the large vessels were removed intact, and on being cleared showed:

1st. Hypertrophy and dilatation of all the chambers of the heart.

2nd. Multiple aneurysmal dilatations of the vessels distributed as follows:

(*a*) A bulging of the aorta to the right just above the valve ring.

(*b*) A small dark-coloured diffuse dilatation just below the origin of the innominate.

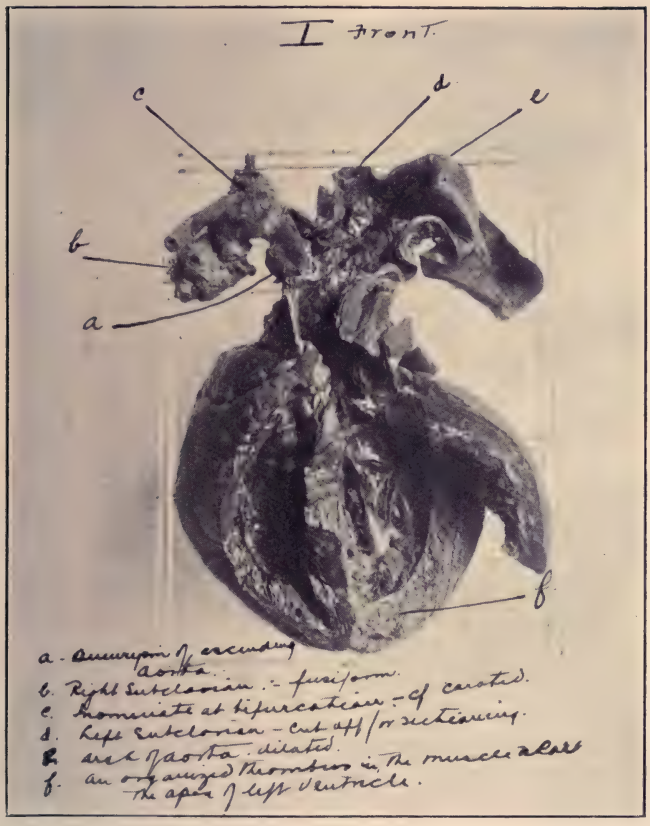
(*c*) The innominate presents two saccular dilatations on its course—one to the right about its middle, and a second which protruded to the left and upward into the suprasternal area. This sac was adherent to the trachea and was ruptured in freeing it. There was no erosion of the trachea.

(*d*) There is a diffuse dilatation of the right subclavian just beyond the bifurcation of the innominate and involving the first and second portions.

(*e*) A fusiform dilatation of the left subclavian.

(*f*) A small cup-shaped dilatation on the arch of the aorta beyond the origin of the subclavian.

The remainder of the thoracic aorta and the abdominal aorta and iliacs are free from dilatations, presenting some gelatinous thickening of the intima in a patchy distribution. The greater part of the lumen of the aneurysm of the innominate, and both subclavians is occupied by a light brown thrombus of laminated structure. There is thrombosis of the basilar artery and the cerebral vessels



a - Aneurysm of ascending aorta.
b. Right Subclavian - fusiform.
c. Innominate at bifurcation - of carotid.
d. Left Subclavian - Cut off in dissecting.
e. arch of aorta - dilated.
f. an organized thrombus in the muscular wall of the apex of left ventricle.

on both sides are distended with purple clot. The combined weight of heart and vessels was 980 grammes.

Histological examination:

Left subclavian artery.—Marked thickening of vasa vasorum of media with perivascular infiltration of round cells. Fragmentation of elastic fibres in a patchy distribution. Marked thickening of intima in areas corresponding to the weakened spots in the media. Commencing organization of thrombus. There is evidence that the medial degeneration is most marked on the outside, or adventitial aspect of the vessel.

Heart.—Section shows: Interstitial fibrous myocarditis with fibrillation of the compressed muscle fibres. Section from apex of L. ventricle shows thrombus with commencing organization.

Cerebrum.—Shows thickening of the small arterioles with extensive peri-vascular infiltration of small cells.

Liver.—Sections show an extensive degeneration, albuminoid, of the peripheral part of the lobules. A small area of liver cords immediately around the central vein being intact with clear staining nuclei, while outside this zone there is atrophy of the cords with a disappearance of nuclei. Great masses of red blood cells are shown in this distribution. There is little increase of the interlobular connective tissue.

The association of two so-called parasyphilitic affections suggests a common mechanism, and it does not seem improbable that the neuron atrophy, and trophic changes in the artery walls are both due to lack of nutrition as a result of the typical perivascular infiltration of syphilis. In this case the changes in the heart muscle and liver are such as one sees in ordinary advanced syphilis.

The diminution in the visible and palpable pulsation as thrombus formation advanced is also of clinical interest, the thrombus formation being in turn coincident with the fall of blood pressure. It is also noteworthy that the radials became synchronous and equal when the aneurysm in the right subclavian became narrowed to the calibre of its original lumen.

BOOK REVIEWS

THE SEXUAL QUESTION. By August Forel, M.D., Ph.S., LL.D., formerly Professor of Psychiatry and Director of the Insane Asylum in Zurich, Switzerland. English adaptation from the Second German Edition. Revised and enlarged by C. J. Marshall, M.D., F.R.C.S., London. Pp. 529. Cloth, price, $5.00. Rebman Company, New York.

This book is the fruit of long experience and reflection by one who is well-known to English readers through the medium of English translations of his other works on psychiatry and kindred subjects. The important part played by heredity is thoroughly recognized by the writer and the importance of educating the public along the lines of prevention is distinctly emphasized. "The law of heredity," as forcibly expressed by Professor Forel, "winds like a red thread through the family history of every criminal, of every epileptic, eccentric and insane person. Should we sit still and witness our civilization go into decay and fall to pieces without raising the cry of warning and applying the remedy."

The subject is treated in nineteen chapters. Chapters I. to VII. begin with embryonic development and deal with the natural history and psychology of sexual life; chapter VIII., with its pathology, and chapters IX. to XVIII., with its social role, that is to say, its connection with the different domains of human social life. The opinions expressed by the writer are based on his scientific study of the human brain and his practical experience as an alienist.

Professor Forel makes it clear that in his judgment exacting laws have never improved the morals of any race or nation; hypocrisy and secret evasion are the only results obtained. He advocates enlightening the masses on the questions of sexual heredity and degeneration. The

opinion is expressed that when the dignity of labour shall once have been raised on the pedestal of worship now occupied by Mammon, there will no longer be need for complaint about small families and decreasing birth rates, such as we hear so much of to-day in France and the United States.

The conclusions reached are happily optimistic and the prospects for reformation are, in the author's judgment, favourable for remedying social conditions so often wrong on account of being improperly understood. The work is certainly a scientific, psychological, hygienic and sociological study, and, while the reader may be strongly inclined to doubt the correctness of the conclusions Professor Forel arrives at, the impression remains that a difficult and delicate subject has been treated in a masterly and scientific manner.

MENTAL SYMPTOMS OF BRAIN DISEASE. By Bernard Hollander, M.D. Rebman Co., N.Y., $2.00.

The author has devoted himself in this work to the investigation of the localization of the mental functions of the brain based on the clinical records and the pathological observations published in medical literature. He cites a great number of cases which illustrate the material basis of our sensations, emotions, instincts and higher mental attributes, and points out where surgery has proved serviceable as a curative measure.

This work is quite a valuable addition to the literature which has a special interest to psychiatrists. It recalls us to the localization of mental symptoms in disease of the brain which may prove more fruitful, now in the light of our improved clinical methods.

The author states in the introduction "that the book deals chiefly with gross macroscopic lesions of the brain due to injury, hemorrhage, tumors, etc., which have been hitherto almost entirely neglected from the point of view of their intimate psychic symptoms, for the asylum physi-

cian rarely gets to see this class of cases and the neurologist fixes his attention almost exclusively on the physical signs of brain disease." J. M. FORSTER.

PHASES OF EVOLUTION AND HEREDITY. By Dr. David Berry Hart, Lecturer on Midwifery and Diseases of Women School of the Royal Colleges, Edinburgh. Rebman & Co., 1123 Broadway, New York. Price, $2.00.

The author in this work has evidently aimed to reach the general intelligent reading public in addition to those interested in biology. He is an optimist who believes that time is steadily evolving a better race and that this improvement is being brought about by educational means more surely and satisfactorily than through legislation. To simplify his subject as much as possible he has appended copious notes and a glossary of scientific terms, while through the text there are many diagrams and explanatory illustrations. The work of Darwin, Weismann, Galton, De Vries and especially of Mendel is dealt with and to the latter is devoted a brief biographical chapter. The author deals with the various theories expounded without prejudice. He is not an adherent to any one school and his own theories and criticisms are given without dogmatism. In the chapter on "Variation," Dr. Hart advances an original theory based on "Quetelet's Law of Probability," which he terms "An intrinsic theory of Variation and its Transmission." Several chapters are devoted to the evolution of the honey bee, while others are devoted to such subjects as: "Heredity in Disease," "The Handicap of Sex," "Evolution in Religious Belief," and "Men who have Revealed Themselves."

From cover to cover the work is one of intense interest and should have a wide circulation.

J. WEBSTER.

SCIENTIFIC FEATURES OF MODERN MEDICINE. (Columbia University Press, New York), is an attempt by Dr. F. S. Lee to present in language not too technical for the intelligent layman, what modern medicine is doing to maintain health, and to prevent, diagnose and treat disease. The chapter headings are:—A Sketch of the Normal Human Body—The Nature of Disease—Methods of Treating Diseases—Bacteria and Protozoa and Their Relation to Disease—The Treatment and Prevention of Infectious Diseases—The Problem of Cancer and Other Problems—Features of Modern Surgery—The Role of Experiment in Medicine—The Public and the Medical Profession.

If the reader is a medical man he will close the book at once, but the lay reader will find in it a sane exposition of those subjects which may be grouped under its somewhat pretentious title. The medical profession has been criticized for its alleged failure to take the laity into its confidence, and to serve as teachers as well as practitioners of its principles. Dr. Lee, through the medium of this work, has probably done valuable service to both the medical profession and the intelligent public, by telling the latter something of what medical leaders have accomplished. E. H. YOUNG.

PSYCHOPATHIA SEXUALIS. By Krafft-Ebing. Published by F. J. Rebman, New York. $4.00.

This is a translation of the twelfth German edition of the book, and discusses the more common forms of perversion and inversion of sexual life.

The first few chapters give a short description of the normal sexual life treated from a physiological standpoint. After this he takes up in regular order: Masochism and sadism, fetichism, homo-sexual feelings, psychical

hermaphroditism, effemination, congenital sexual inversion in woman, antipathic sexual instinct, nymphomania and satyriasis.

Then follow a few pages devoted to the legal aspect of pathological sexuality, including offences against morality, robbery and lust-murder, torture of animals dependent on sadism, masochism and sexual bondage, robbery and theft dependent on fetichism, sexual offences caused by delusions, sodomy, bestiality, cultivated pedestary, lesbian love, mecrophilia in incest.

All these various pathological conditions are described and illustrated by short histories of type cases. Anything that might arouse the lay mind is printed in Latin so as to prevent any but those for whom the book is intended becoming interested in the subject.

This book is well written and gives a description of an unpleasant subject as modestly as possible. The book is intended for jurists, judges, alienists and criminologists and will be found very useful by any of these who may choose to interest themselves in the subject.

H. Clare.

Treatise on Diseases of Skin (Sixth Edition). By Henry W. Stelwagon, M.D., Professor of Dermatology, Jefferson Medical College, Philadelphia. 289 illustrations. 1,200 pages. Published by W. B. Saunders Co., Philadelphia. Canadian Agents, The J. F. Hartz Co., Toronto. Price, $6.00.

That this work should have reached a sixth edition in such a comparatively short period of time is sufficient evidence of its well earned popularity.

In his earlier preface the author gives as his aim the production of a book that will give to those engaged in general practice "a full comprehension of the symptomatology, diagnosis and treatment of the various skin affections with which they are likely to come in contact."

That he has fulfilled his aim, those familiar with the earlier editions will freely acknowledge, and it is scarcely necessary to say that this, the sixth edition, only adds to the high reputation the work has already attained.

In this edition there has been a thorough revision and some new material added, the latter dealing principally with the skin diseases peculiar to tropical conditions. The numerous plates are clear and distinct and uniformly excellent and will prove a great help to the physician in his diagnosis. To those engaged in general practice, who see relatively but few cases of skin disease, such a book as this is invaluable and almost indispensable.

W. K. Ross.

EDUCATION AND PREVENTIVE MEDICINE. By Norman Edmund Ditman, Ph.D., M.D.

This article has just been published, being written for the *Columbia University Quarterly* in 1908. It is a plea for the establishment of a school of preventive medicine. As much interest is manifested at present in the prevention of disease the essay is particularly interesting. The author discusses all the preventable diseases from the time of our earliest records and gives charts showing the decrease in the death rate. In conclusion the author advocates the establishment of a special health board which should supervise the general health board of the country at large. Provincial health boards should be in charge of the local territory. This is the same arrangement as obtains at present in both Canada and the United States. The important principle advanced is that men serving as health directors should be specially trained and that a school for the study of the prevention of disease should be established and that the public should be given the benefit of its activities, with special attention to students of medicine, school teachers, school

inspectors, nurses, ministers and legislators. The article should be interesting to everyone having the health of the nation at heart. Statistics given should bring about a change of thought in those who are inclined to be parsimonious in expending money for the production of a pure water supply, the prevention of lake and river contamination, the education of the public concerning tuberculosis and all other diseases with reducible death rates.

F. NEELY.

Printed by
WILLIAM BRIGGS,
29-37 Richmond Street West,
TORONTO.